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ABSTRACT

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Empathy: The Critical Factor in Conflict-Resolution and a Culture of Civility

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Abstract

Empathy is a critical factor in maintaining peace, respect and civility in our schools. The experience of reciprocal affect and accurate perspective taking comprise the components of empathy and stimulate the motivation to ameliorate the condition of another. The cognitive, physiological and social development of empathy is described with consideration to factors impairing empathic development and expression. Remedial, preventative and promotional interventions that enhance empathy and prosocial behavior are described emphasizing their synergistic features.

Empathy: The Critical Factor in Conflict-Resolution and a Culture of Civility

Introduction & Statement of the Concern:

Since the Columbine mass murders, the attention of every segment of our country has been on the safety of our children and students in our schools. More specifically, the focus has been on the nature and prevalence of conflict and violence, as manifested in taunting, bullying, fighting, vandalism, enraged aggression and pre-meditated acts of murder (Nansel et al., 2001). In it's broadest and most systemic perspective, the focus of attention has been on the culture of civility and harmonious interaction that may or may not characterize our schools. In virtually every school district and community throughout our country, educators, parents, government and law enforcement officials have struggled to ensure safety in our schools and maintain school cultures of civility and social harmony. Some efforts have been successful, while others have not.

Since 1995 there have been a plethora of safe school and conflict resolution initiatives (Sandhu & Aspy, 2000). Many of these efforts have emphasized the physical qualities of safe schools: locked doors, surveillance cameras, metal detectors, and police presence (Stephens, 1998). Although sometimes necessary interventions, depending upon their context, these physical safety precautions are insufficient in creating school norms of civility, respect and prosocial behavior. It is this school culture of civility and mutual respect that is most critical in ensuring safe schools (Nims, 2000). Additionally, whereas our initial reaction to school violence was to identify and remediate (or eliminate in the enforcement of zero tolerance policies) the perpetuators of violence, a more reasoned and pervasive response has recently directed attention to prevention through the promotion of prosocial behavior. This proactive promotion calls for a wide range of systemic interventions ranging from individual remediation (instructional, clinical

and judicial) to classroom based curricular initiatives, and ultimately to school wide policies and procedures that promote norms of acceptance, empowerment, communication, accountability and respect. Whether individually or systemically taught, modeled and enforced, these initiatives emphasize anger management, social problem solving and the maintenance of clear, consistent contingencies for pro and antisocial behavior.

What these initiatives often fail to consider is the crucial role that empathy plays in the daily display of anger control, conflict resolution and civility (Davis, 1994; Eisenberg, Wentzl, & Harris, 1998; Feshbach, 1973). The absence of developmentally appropriate empathy has been shown to be a major contributor to acts of aggression (Feshbach, 1979), while its presence is the fundamental influence upon a culture of safe and humane schools. Until recently (Cadoret, Yates, Troughton, Woodworth, & Stewart, 1995) we assumed that empathy was a personality construct that we possessed on a continuum of biological determination. Those who possessed it in ample amounts were the peacemakers; those deficient were doomed to a life of conflict and social ostracizism. In either case we failed to realize the social/environmental influences upon its development and manifestation. Consequently, we failed to consider that it could be deliberately learned, and thus deliberately taught. This realization now has empirical support (Denham & Almeida, 1987; Feshbach, 1979; Goleman, 1995; Grossman et al., 1997) and prompts us to regard empathy as a critical human skill susceptible to social influence and deliberate instruction.

The purpose of this paper is to describe the etiology, development, social manifestations, treatment implications and training of empathy, especially within the context of our schools. In describing this cognitive-affective dimension of personality, the authors will highlight the causes and expressions of empathic dysfunction. From this grounding in its description, development

and dysfunction, the authors will present an overview of counseling, instructional and systemic interventions that deliberately teach, model and maintain the essential elements of empathy. The paper will close with a call for the role that empathy training can play in building and maintaining a culture of peace, respect and civility within their schools.

Definition, Development and Disability

Definition

A child is experiencing empathy when he or she views another child who is sad because her puppy has been lost and vicariously feels sad as a consequence. The reciprocal feeling of sadness and the accurate perspective taking (e.g. that the puppy was lost) represent the two critical components of empathy. It is from this experience of accurate empathy that this young observer is motivated to help in the search, attempting to ameliorate the condition of the other.

Were the observer in our example only to experience a highly intense emotion of sadness to the exclusion of accurate perspective taking, he or she would probably experience a self-focused negative emotion leading to personal distress (Batson, 1991; Eisenberg & Fabes, 1992). Motivated by personal distress, the observer would act only to relieve his or her own sadness, usually by withdrawing from the aversive situation. A number of studies by Nancy Eisenberg (Eisenberg, Fabes, Shepard, et al., 1998) have shown that children who are prone to intense and frequent negative emotions are low in empathy. Their inability to manage negative emotions interferes with their capacity to affectively and cognitively empathize with others.

Children who are disabled in vicariously experiencing the emotions of others will only act in ways to assuage their own needs or emotional state. However, even if they are able to accurately identify and experience the emotions of others, they will not experience complete empathy and the motivation to mitigate the distress of others unless they can understand the

cognitive perspective of those in distress. It is also hypothesized (Eisenberg, Wentzl, & Harris, 1998) that the cognitive ability to understand the perspective of others contributes greatly to self-regulation of emotional arousal. For example, an enraged person will attenuate his or her anger as he or she comes to understand the perspective of others in a conflict situation. Eisenberg, Fabes, Shepard, et al. (1998) also found that accurate cognitive perspective taking could actually increase children's emotional arousal and empathic responding. These researchers concluded that social skill training programs that emphasize children's understanding and control of emotion contribute to the development of empathy, and that those programs that treat empathy and emotional self-regulation as outcomes have resulted in increased social competence and reductions in behavioral problems.

Development

Empathy is the ability to identify, experience and understand the emotions of others and act to reduce the negative emotions exhibited by others. This capacity to affectively and cognitively identify with others is the product of an evolving bio-social developmental process and necessitates maturation, experience and social interaction (Brothers, 1989; Hoffman, 2000).

Mature empathy involves the complex interaction of emotion, cognition and operant behavior, reflecting the developmental convergence of all three systems. Drawing upon the work of Simner (1971), Hay, Nash, and Pederson (1981), Radke-Yarrow and Zahn-Waxler (1984), Kaplan (1977), Lewis and Brooks-Gunn (1979), Strayer (1993), and Pazer, Slackman, and Hoffman (1981), Hoffman (2000) identifies four broad stages in the development of empathy: 1) unclear or confused self-other differentiation; 2) awareness of self and others as physically separate; 3) awareness of self and others as having different internal states and; 4) awareness of self and

others as having different histories, identities and lives beyond the immediate situation. The final stage includes the development of generalized perspective taking.

The emotional experience of empathy develops as children mature socially and cognitively. According to Brothers (1989) and Hoffman (2000), empathy is a hard-wired, innate, neurologically based emotional arousal system. The newborn reactive cry is the first rudimentary affective manifestation of empathy, as the involuntary response to another's emotion leads the newborn to experience the same emotion. An innate reaction, newborns will spontaneously cry at the sound of another's cry, probably experiencing the other as part of themselves (Hoffman, 2000; Snow, 2000). The reactive cry involves a form of negative affective mimicry, as infants' contorted facial muscles associated with their cries send them into an agitated state, and they actually feel the same emotion as the other. The fact that newborns hear the other's cry at the same time as they feel personally distressed may lead them to experience empathic distress in the future when they see another in distress. Positive affective mimicry also occurs when infants imitate the positive affect of their caregiver, a smile for example, and feel empathic happiness as they smile in return. Affective mimicry leads to conditioning, providing a cue associated either with previous pain or discomfort or previous feelings of contentment.

After the age of six to eight months, with the development of object permanence, infants begin to learn to differentiate themselves from others (Hoffman, 2000; Piaget & Inhelder, 1969). They no longer respond spontaneously to the sound of another's cry, instead attempting to moderate their own empathic distress in a purposeful way. Still unclear about self-other differentiation, infants experience "egocentric empathic distress," doing the same thing to relieve their empathic distress as their own distress (Hoffman, 2000).

Empathic responding to others first occurs in the second year (Lamb, 1991) when toddlers make their first attempts to help the victim, tentatively patting and touching, then actually attempting to physically assist the other child, getting help or providing reassurance (Radke-Yarrow & Zahn-Waxler, 1984). While children become capable of labeling their own feeling states during the second year (Bretherton & Beeghley-Smith, 1982), the toddlers do not yet realize that others have different inner states than their own, and in "egocentric confusion" they attempt to relieve the victim's distress in the same way that they would relieve their own distress (Hoffman, 2000). Clearly this does not always work, leading to further cognitive accommodation.

By the middle of the second year, children begin to show awareness that others have different inner states than their own (Lewis, Sullivan, Stranger, & Weiss, 1989; Reingold & Emery, 1986). Hence they now start to empathize more accurately. "Veridical empathy" occurs as children become cognitively ready to learn from corrective feedback after making "egocentric mistakes" (Hoffman, 2000). Children can now empathize with the victim in distress, accurately identifying a negative feeling and attempting to ameliorate the victim's distress. This is not what will later become true perspective taking, but this stage has the essential elements of the mature empathy that will develop as the child grows.

Between the ages of three and five, children begin to understand the causes, consequences and correlates of emotions and especially that feelings can effect a person's facial expressions, feelings can result from another's action, and feelings can elicit action from others (Hoffman, 2000). Pre-school age children start to realize that the same event can produce different emotions in different people (Hoffman, 2000). By the age of six or seven, children begin to self-reflect and appreciate that others have their own unique life experiences (Hoffman,

2000). They understand that their own emotion can be an empathic response to what happened to someone else. At the age of nine or ten, children comprehend that the same event may cause different or conflicting feelings. This cognitive shift sets the stage for ages twelve to thirteen, when they are able to understand that feelings that are expected in a situation are not always what are actually felt.

Another dynamic that influences empathic development is the physiological and anatomical development of the brain. The cognitive executive function of the brain evolves physiologically, anatomically and through environmental interaction, not reaching maturity until adulthood (Baird et al., 1999; Cepeda, Kramer, & Gonzalez de Sather, 2001). While the affective components of empathy are present at birth, the cognitive components of empathy unfold as children slowly mature into adolescence and finally into adulthood. According to Hoffman (2000), affect-based mimicry and conditioning lead to higher levels of cognition through the occurrence of direct association, verbal mediation and role taking. Direct association takes place when cues in the situation of another person remind the observer of similar experiences in his or her own past and consequent feelings are evoked that fit the other's situation. At a higher cognitive level, verbal mediation allows the observer to imagine another's situation simply by processing the other's language so that the observer may respond via direct association. Finally, through role taking, one may realize the highest level of empathy by putting oneself into another's place and imagining how the individual feels in that situation. Hoffman (2000) states that role taking operates on three interdependent and superordinant levels: self-focused, other-focused and combination role taking.

Self-focused role taking involves the observer putting him or herself into the experience of another and imagining how he or she would feel in the same situation. While intense empathic

affect is often produced, these feelings may evoke memories of the observer's personal experience, leading his or her attention away from the other and back to him or herself. Other-focused role taking directly targets the person being observed, imagining how he or she feels and relying on that person for affective cues in order to feel what he or she is feeling. Combination role taking relies on the capacity of the observer to switch back and forth between self-focused and other-focused role taking. This combination may be the most effective as it unites the intense emotion of self-focused role taking with the sustained attention of other-focused role taking.

Mature empathizers understand (i.e. assume the perspective) and emotionally experience the state of another without having direct exposure to either the other person's affect or their situation. Mature empathy moves perspective taking from immediate stimulus comprehension to a generalized, hypothetical condition. Essentially, the observer becomes able to see beyond the immediate experience of others and empathize with their general condition. The broadest form of perspective taking is the development of concepts or schemas related to specific episodic sequences. For example, the observer need not have every day contact with homeless individuals to empathize with the chronically unpleasant conditions of homelessness. This ability to generalize empathy to a hypothetical condition reflects mature empathy.

Disability

When mature empathy exists it motivates such prosocial behavior as sharing, sacrifice and norm observing (Reykowski, 1982). These prosocial effects of empathy have been explained theoretically (Batson, 1991; Eisenberg, 1982; Eisenberg & Mussen, 1989; Hoffman, 1982, 2000) and numerous studies have empirically supported this relationship (Davis, 1994; Eisenberg & Fabes, 1990; Eisenberg & Miller, 1987; Eisenberg-Berg & Mussen, 1978; Feshbach & Feshbach, 1986; Miller & Eisenberg, 1988). The effects mediated by empathy also include social

understanding, increased self-awareness, enhanced communication skills, heightened compassion and caring, and regulation of aggression and other anti-social behaviors (Feshbach, 1973). While empathic affect motivates caring and justice (Hoffman, 1991), its absence is associated with aggression (Feshbach, 1979; Feshbach & Feshbach, 1969; Huckabay, 1972; Mehrabian & Epstein, 1972). There are extant forces in our social and physical development that can inhibit and disable empathic acquisition and expression. We will next address some of the more prominent factors.

It is often assumed that empathy will naturally develop as a child grows, however, disruptions in empathic development can occur at any point. In today's fast-paced, hi-tech and often violent society, the development of empathy may be disrupted more easily than ever, resulting in higher levels of aggression and violence. Disablers of empathy may include physiological/genetic defects, a lack of early bonding with and attachment to caregivers, abuse or neglect and dysfunctional social/environmental learning experiences.

Physiology plays an important role in the potential disabling of empathic development. Deficits in brain function may predispose a child to have difficulty in the natural development of empathy. One study (Schreiber, 1992) of juvenile delinquents who were unable to identify their own or others' feelings showed that many of these children were born to mothers who had used drugs during their pregnancy. As adolescents, these delinquents showed evidence of neurological dysfunctions. Moreover, children diagnosed with Attention-Deficit/Hyperactivity Disorder are often unable to accurately empathize with others; their emotional dysregulation is caused by biochemical imbalances within the frontal cortex and related executive functions (Barkley, 1998). Based on their research findings, Feshbach and Feshbach (1983) suggested that for a developmentally appropriate empathic response to occur, both cognitive and affective

components must work in conjunction. She further suggests that a breakdown in the cognitive component of empathy causes a dysregulation in the affective response, leading to inaccurate and egocentric emotive responding. While the exact role that genetics play in the facilitation of empathic development and prosocial behavior is unknown, some theorists (Boyd & Richardson, 1985; Lumsden & Wilson, 1981) have posited that while genes prescribe the biological processes that control the development of the brain, these processes are dependent in part on each individual's social/environmental context. Essentially, genetic and cultural factors appear to be interdependent in the development of social behavior and empathy.

Disturbances of attachment in a child's early years may increase the risk for antisocial behavior in later childhood or adolescence (American Psychiatric Association, 2000). If bonding between infant and caregiver does not occur in infancy and early childhood, the development of mature empathy may be disabled (Boris, Zeanah, Larrieu, Scheeringa, & Heller, 1998; Karen, 1990; Zeanah, 1996). Early bonding gives the child a sense of trust, intimacy and security and provides a base for sociability. As indicated by Sroufe (1983), children who were not securely attached at 12 and 18 months tended to be hostile and socially isolated. Reactive Attachment Disorder is a condition often associated with severe emotional detachment of children under the age of 5, in which children have difficulty forming genuinely affectionate relationships and exhibit developmentally inappropriate social relatedness (American Psychiatric Association, 2000; Attachment and Bonding Center of Pennsylvania, n.d.). These children are frequently unable to identify and explain their own feelings (Attachment and Bonding Center of Pennsylvania, n.d.) hence they are unable to empathize with others. While the introduction of a supportive and caring environment may considerably improve a child's chance for recovery from an early lack of attachment (American Psychiatric Association, 2000; Attachment Center at

Evergreen, n.d.), the longer a child goes without attachment to his caregiver, the less likely it is that he will ever "catch up" to developmentally appropriate levels of empathy.

Physical and emotional abuse and neglect by caregivers in the early years can also inhibit empathic development. In a study (Main & George, 1985) observing abused and non-abused 1- to 3-year-olds, none of the abused children expressed the concern, sadness or empathy that was often exhibited by the non-abused children. Instead, the abused children reacted to their peers' distress with fear, anger and even physical attacks. Other studies (Miller & Eisenberg, 1988; Straker & Jacobson, 1981) have also evidenced that abused children have lower levels of empathy than their non-abused peers. Child abuse and neglect creates intense negative emotions, but these emotions are ignored, invalidated, or violated by caregivers (Paivio & Laurent, 2001). In order to survive emotionally, abused children dissociate from their own negative emotional state, shutting down their capacity for empathy. This affect dysregulation can result in long-term impairments in functioning, including chronic depression and anxiety, numbing of affective experience, difficulty in recognizing and describing emotional experience, anger control problems, and self-esteem and interpersonal difficulties (Paivio & Laurent, 2001). In severe cases of physical and sexual abuse this dissociative coping mechanism results in multiple identities of disintegrated sense of self, memory and consciousness (American Psychiatric Association, 2000).

Social and environmental cues, including parents, other significant adults, peers, and the media play a large part in the learned empathic response. Children will naturally mimic parental figures, including those who model prosocial behavior and empathy (Eisenberg & Mussen, 1989; Zahn-Waxler, Radke-Yarrow, & King, 1979) as well as those who show that aggression is an appropriate and useful way to meet needs (Patterson, DeBaryshe, & Ramsey, 1989; Perry, Perry,

& Rasmussen, 1986). Schreiber (1992) found that unwed teenage mothers who were living under deprived and highly frustrating conditions often tuned out the distress of their babies, leaving the infants no choice but to tune out and deny the effects of suffering in themselves and in others. Later, these children were unable to recognize or describe any feeling states. Sroufe (1995) emphasized the importance of parental empathy in establishing the secure attachment bond that is the basis for developing emotion regulation capacities. With minimal bonding and parental support, children do not learn to manage intense negative emotion, resulting in either emotional underregulation or overcontrol (Paivio & Laurent, 2001).

Our ubiquitous media has a pervasive influence over empathic development. Violent video games and television programs teach children that aggression does not have negative consequences, but instead contributes to power and control. A child's natural empathic response is diminished as the victim is depersonalized and the aggression is reinforced. A wide variety of studies have shown a causal effect between television violence and child and adolescent aggressive behavior (Fredrich-Cofer & Huston, 1986). Eron (1987) showed that 8-year-olds who frequently watched violent television programs were more aggressive than their peers who watched violent programs less often, and 22 years later, they were still highly aggressive and were more likely to be convicted of serious crimes. When combined with his or her individual physiology, a child's environment may have a profound effect on the inhibition or facilitation of empathic development.

Several disorders noted in the DSM-IV-TR (American Psychiatric Association, 2000) are characterized by a lack of empathy. Individuals with Conduct Disorder may display bullying and threatening behavior, steal or destroy property and physically harm people or animals, with callous disregard for the feelings and rights of others. Antisocial Personality Disorder

(previously known as psychopathy and sociopathy) is an extension of Conduct Disorder's antisocial behavior into adulthood, including aggressiveness, deceit, manipulation, reckless disregard for others, and lack of remorse for wrongdoing. Narcissistic Disorder, while typically not aggressive, is characterized by a lack of empathy and inability to recognize or identify the feelings of others while having a grandiose sense of self-importance and entitlement. These disorders may have both genetic and social/environmental links. Adoption studies (American Psychiatric Association, 2000) have indicated that while children resemble their biological parents, the adoptive family environment influences the risk of developing a Personality Disorder. Hence, while a child may have a biological predisposition to aggression or a lack of empathy, his environment may dictate whether that predisposition is cultivated or inhibited.

Interventions: Remediation, Prevention and Promotion

As we realize the critical importance of empathy in effective conflict resolution and prosocial behavior, the question of deliberate interventions for empathy development, learning and maintenance comes to the fore. School-based initiatives can be classified as those providing clinically based direct instruction of developmentally appropriate empathy; classroom-based comprehensive developmental conflict resolution and anger management programs that incorporate empathy learning as an integral part of the curriculum; and school- (or district-) based systemic interventions that attempt to promote and maintain empathy as a cultural norm. The clinical or tertiary remedial interventions are directed toward our most violent youth while the classroom-based programs target all students at specific age or grade levels. Broadest of all are the school-based initiatives that attempt to influence the entire school culture, it's policies, procedures, and norms of acceptable and unacceptable behavior that are known and enforced by everyone. It is beyond the scope of this paper to discuss the myriad examples and their empirical

support for each category. Rather we will cite a few of the more prominent and effective initiatives that have been employed in our schools.

Interventions for Remediation

School based remediation efforts (Lochman, 1992; Lochman, Burch, Curry, & Lampron, 1984; Lochman, Nelson, & Sims, 1981) have focused upon decreasing disruptive and aggressive behavior through individual and group counseling and behavior modification strategies (Kazdin, 1987). Interventions through individual and small group counseling have focused upon anger management, stress management, impulse control and social problem solving.

Stress and anger management training show some success in improving problem-solving and reducing substance abuse (Lochman, 1992), but have not focused upon empathy per se. Social problem solving for aggressive behavior has shown some success (Rubin, 1991), although in-school interventions with chronic offenders, those diagnosed for Conduct Disorder, and accounting for nearly 75% of all violent juvenile crime (Thornberry, Huizinga, & Loeber, 1995), have shown little success (Kazdin, 1997).

Overall, school-based interventions such as individual and group counseling, in-school suspension and alternative school have not been found to reduce antisocial and aggressive behavior (Short & Shapiro, 1993). Moreover, negative behavior management, punitive and inconsistent discipline with minimal attention to positive behavior can contribute to onset and maintenance of Conduct Disordered behavior (Kamps & Tankersley, 1996)

Classroom-Based Prevention

Five years before the Columbine shootings there were more than 300 violence prevention programs and more than 100 conflict resolution curricula for middle and high school students (Lawton, 1994). These classroom based initiatives adhere to a public health model of primary

prevention (Hamberg, 1998), and offer developmentally appropriate (for needs, tasks and abilities) curricula designed to teach the knowledge and skill required for effective violence prevention and social effectiveness. According to a major governmental study (Safe Schools, Safe Students, 1998) of program effectiveness, to be effective, these programs must include nine critical elements, one of which includes skills training that is strongly based upon a theory of prosocial and cognitive development. Few of these programs built their curricula upon a foundation of empathy training. In her more recent review (Lawler, 2000) of 84 extant programs, only 20 programs were empirically researched and meeting some of the nine criteria. Of the programs reviewed, the majority emphasized anger management, social problem solving, impulse control and assertiveness skills. Two of the programs, Second Step (Beland, 1996) and Aggression Replacement Training (Goldstein & Glick, 1987) incorporate perspective taking into their curricula, with Second Step devoting the first quarter of its Pre-Kindergarten through ninth-grade curricula to empathy development.

The Second Step Program is a developmentally, theoretically and empirically based curriculum (Beland, 1996) designed to teach skills in empathy, impulse control, problem solving and anger management. Its foundation is laid at each grade level from pre-kindergarten to grade nine with the first unit devoted to empathy. During these initial units, the students learn the basic ingredients of empathy: to accurately identify their own feelings; to determine the emotional state of another person; to know and understand the perspective and role of another person; and to accurately respond emotionally to another person. Students are then taught to use their accurate empathy to recognize conflict and the feelings involved, use "I" messages, actively listen to others, and express care and concern for both themselves and others. From this foundation of affective and cognitive empathy, subsequent units teach students ways to control

their anger and aggressive impulses, to resolve conflicts from a "Win-Win" orientation, and to assert their needs and rights without violating those of others.

An early curriculum designed to enhance children's empathic skills as a method of reducing aggressive behavior was the Empathy Training Program (Feshbach & Feshbach, 1982). Targeting students in grades 3 to 5, this classroom curriculum taught skills in identifying emotions, discriminating emotions in oneself and others, and developing the ability to take the perspective of another. When measured against a control group receiving training in social problem solving, the empathy-training group showed marked improvement in prosocial behavior (e.g. cooperation, helping and generosity) and self-concept. During the same period, Spivak and Shore (1982) incorporated the teaching of emotion-related skills as part of their classroom based Interpersonal Cognitive Problem Solving (ICPS) program. Children were taught how to identify emotions, conceptualize others' emotions, and reflect on the rationale for differences found, all forming the bases for interpersonal problem solving. Outcomes of the ICPS program include improved problem-solving skills, increased prosocial behavior and decreased maladaptive behaviors.

The Promoting Alternative Thinking Strategies (PATHS) project attempts to improve emotional and prosocial competence in both regular and special education first-to third-grade students (Greenberg, 1996). Through this classroom-based program, students are taught to identify their emotions and the emotions of others and to manage their feelings. As a result of this emotion awareness and self-control focused curriculum, both regular and special needs students improved their empathy (as measured by the Kusche Affective Interview) and interpersonal problem solving. Both groups of students in the PATHS program displayed significantly less aggressive solutions to interpersonal problems and were able to maintain their

gains in self-regulation, recognition of feelings and conflict resolution over 18 months after the end of training (Greenberg & Kusche, 1997).

Systems-Based Promotion of Safe Schools

As with all social systems, a school community shares reciprocal influence with each population and operation existing within that system. The cultural norms of a school affect the thoughts, feelings and actions of every student, teacher, administrator and parent affiliated with that school. Conversely, the disposition of each member of the school community influences the nature and maintenance of those norms. School policies, procedures, structures and processes all influence the development and maintenance of empathy in every segment of the school population. Since accurate empathy and emotional self-regulation are significant variables in increasing social competence and reducing problem behavior (Eisenberg, Fabes, Shepard, et al., 1998), it is incumbent upon educators to purge systemic factors that sustain violence and aggression and promote factors that enhance empathy and civility.

Some of the more pervasive systemic problems that contribute to violence and aggression (directed at self and others) include disenfranchisement, discrimination and unrealistic performance expectations. Disenfranchisement occurs when the system offers no forum to air and resolve grievances or is devoid of collective or representative decision making, leading individuals to feel unaccepted, powerless and resentful. Discrimination, including all of the "isms" from gay bashing (Teague, 1992) to racial hate crime (Sandhu & Aspy, 1997) can neither be fostered by the system nor be addressed with benign neglect. When the system maintains unrealistic standards for success and recognition, individuals consistently experience stress, anxiety and depression. These debilitating states often result in aggression directed at self (mutilization and suicide) or others (Wagner, Cole, & Schwartzman, 1995).

The report by Safe Schools, Safe Students (1998) offers a number of systemic initiatives that promote safe and harmonious schools. Included in their recommendations are:

- Clear and specific norms of acceptable and unacceptable behavior
- Comprehensive and multifaceted approach
- Coordination across programs
- Physical and administrative changes (many cited)
- Training for total school staff
- Multiple teaching methods that accommodate diverse learning styles
- Cultural sensitivity and formal structures that integrate diverse populations

One of the earliest systems-based intervention programs was the Child Development Project (CDP) (Battistich, 1991). This school wide program involved parents and teachers in helping their children to understand the needs, feelings and perspectives of others. The goal of this multi-faceted intervention program was to create a school community where teachers and students care about and support each other, sharing common values, norms, goals and important decision-making. Although empathy was not an outcome measure of the CDP, concern for others, altruistic behavior, learning motivation, conflict resolution skills and liking school were all demonstrated outcomes (Battistich, 1997).

Conclusion

There is considerable support in the expository and research literature for the importance of empathy in conflict resolution and prosocial behavior and for the deliberate teaching of empathy (both affective and cognitive components) to school age students. Without developmentally appropriate levels of empathy, children are at risk for violent and aggressive behavior that may continue into adulthood. Unfortunately, the teaching of empathy skills has been a small or absent

component of the broad based programs for conflict resolution and social problem solving. Those programs that do address empathy training frequently take a kitchen sink approach by including the full range of intra and interpersonal skill building and classroom management into their curricula. Often, when empathy is deliberately taught, the emphasis is given to the emotional component rather than to the synergistic relationship between vicariously experienced emotion and cognitive perspective taking. Very few interventions to date have given adequate attention to the development and maintenance of complete empathy with it's affective and cognitive components operating in synergy.

Complete empathy is the crucial ingredient that must be taught, modeled, reinforced and experienced by all. In the remediation of students disabled in some aspect of conflict resolution or anger management, the teaching of conflict resolution and prosocial skills within a classroom guidance curricula or the maintenance of a school climate in which peace and respect are the norm for everyone, empathy is the critical factor in a culture of civility.

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